STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395262	A. BLDG: 00 B. WING:	02/04/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
GREENFIELD HEALTHCARE AND REHABILITATION CENTER STATE LICENSE NUMBER: **490802**	**1521 WEST 54TH STREET ERIE, PA 16509**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT Based on a Medicare/Medicaid Recertification, State Licensure, and Civil Rights Compliance Survey and an Abbreviated Complaint Survey, completed February 4, 2025, it was determined that Greenfield Healthcare and Rehabilitation Center, was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		
F 0561 SS=D		F 0561		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: | (X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0561 SS=D	Continued from page 1 483.10(f)(1)-(3)(8) Self-Determination §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by:	F 0561	Residents # 2 and #68 bath/shower preferences were reviewed All residents bath/shower preferences were reviewed by the Director of Nursing/designee Nursing staff will be educated on resident preference and completing showers as per resident preference by the Director of Nursing/designee and documentation of bath/shower An audit will be conducted by the Director of Nursing/Designee on resident's bath records and 5 resident interviews to ensure that residents preferences are being met, and documentation will be reviewed 3 times a week for 4 weeks then 2 times a week for 4 weeks then monthly ongoing. The audit will be monitored by the Administrator. Findings will be reported to the Quality Assurance Performance Improvement committee for review and recommendations.	Completion Date: **03/28/2025** Status: **APPROVED** Date: **03/03/2025**

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F 0561 SS=D	Continued from page 2 Based on a review of facility and clinical records, resident and staff interviews, and observations, it was determined that the facility failed to provide a bath/shower as resident preference for two of 21 residents reviewed (Residents R2 and R68). Findings include: A facility policy, "Resident Showers," dated 11/01/24, revealed it is the practice of this facility to assist residents with bathing to maintain proper hygiene, stimulate circulation and help prevent skin issues as per current standards of practice. Residents will be provided showers as resident preference. Resident's R2's clinical record revealed an admission date of 12/28/23, with diagnoses that included lupus (a disease when the immune system attacks your own tissue and organs), chronic obstructive pulmonary disease (a group of diseases that affects the lungs and breathing), heart disease, and rheumatoid arthritis (a chronic inflammatory	F 0561		

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F 0561 SS=D	Continued from page 3 disorder that typically affects the hands and feet). During an interview with Resident R2 on 1/28/25, at 2:25 p.m., he/she indicated their bath/shower was scheduled for Wednesday and Saturday evenings, but he/she has not received scheduled bath/shower in the past several weeks. Resident R2 verbalized, "I am really easy. All they have to do is get me in the shower room and up over a hump, and I can do the rest. I end up washing my hair and washing up in the sink here in my room cause I stink." Review of Resident R2's bath/shower documentation for 12/28/24, through 1/28/25, revealed he/she was scheduled for a bath/shower on Wednesday/Saturday 3-11 p.m., however, no bath/shower was provided on 12/29/24, 1/01/25, and 1/15/25. Resident's R68's clinical record revealed an admission date of 7/06/24, with diagnoses that included hemiplegia and hemiparesis following cerebral infarction (neurological conditions that	F 0561		

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F 0561 SS=D	Continued from page 4 cause weakness or paralysis on one side of the body after a stroke), aphasia (a language disorder that affects a person's ability to communicate), muscle weakness, and unsteadiness on feet. During an interview with Resident R68 on 1/28/25, at 2:30 p.m., he/she indicated their bath/shower was scheduled for Wednesday and Saturday evenings, but he/she has not received a shower since 1/14/25. Resident R68 verbalized, "We are told also that the staff does not give showers on Sunday, so we never know when we will be getting an actual shower. But the last time I had water running over me was the 14th." Resident R68 was observed looking at his/her phone where he/she had the shower documented. Resident R68 was observed with greasy hair. Review of Resident 68's bath/shower documentation for 12/28/24, through 1/28/25, revealed he/she was scheduled for a bath/shower on Wednesday/Saturday 3-11 p.m., however, no bath/shower was provided on 12/29/24, 1/01/25,	F 0561		

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F 0561 SS=D	Continued from page 5 1/12/25, 1/19/25, and 1/26/25. An interview with the Regional Clinical Consultant on 1/31/25, at 12:55 p.m. revealed frequency of Baths/Showers are based on resident preference and confirmed that baths/showers were not provided according to residents' scheduled days and preference for the period of 12/28/24, through 1/28/25, for above noted residents. 28 Pa. Code 211.10 (d) Resident care policies 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services	F 0561		
F 0580 SS=D		F 0580		

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F 0580 SS=D	Continued from page 6 483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this	F 0580	Resident # 51 responsible party was notified by the Director of Nursing or designee Residents were reviewed for the last 30 days for change in condition, change in orders, and/or transfer to ensure resident and/or responsible party were notified by the Director of Nursing/designee Licensed staff will be educated on timely notification of change in condition, change in orders, and transfer of resident to resident and/or resident representative and notifying appropriately by the Director of Nursing/designee An audit will be conducted for those residents that have a change in orders or transfer to the hospital to ensure resident and/or resident representatives are notified timely of change in orders or transfer to hospital 5 times a week for 4 weeks then weekly for 4 weeks and then ongoing by the Director of Nursing/designee Findings will be reported to the Quality Assurance Performance	Completion Date: **03/28/2025** Status: **APPROVED** Date: **03/04/2025**

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F 0580 SS=D	Continued from page 7 section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by:	F 0580	Improvement committee for review and recommendations.	

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F 0580 SS=D	Continued from page 8 Based on review of facility policy and clinical records, review of the Long Term Care Facility Resident Assessment Instrument 3.0 User's Manual 2019 (RAI-assessment guide used to plan the provision of care for residents), and staff interviews, it was determined that the facility failed to notify the resident's representative of a change in condition timely for one of 21 residents reviewed (Resident R51). Findings include: The facility policy entitled "The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification." Resident's R51's clinical record revealed an admission date of 3/23/22, with diagnoses that included multiple sclerosis (a disease in which the immune system destroys the protective covering of	F 0580		

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F 0580 SS=D	Continued from page 9 nerves resulting in nerve damage disrupting communication between body and brain), Alzheimer's disease (a disease of the brain resulting in mood and behavioral changes and poor decision making), neuromuscular dysfunction of the bladder (a condition where the nerves controlling bladder function are damaged), and muscle weakness. Review of the RAI manual for Section C0500 "Brief Interview for Mental Status (BIMS)" revealed that a score of 13-15 identified a resident as cognitively intact and a score of 8-12 identified a resident as moderately impaired, and a score of 0-7 as severely impaired. Resident R51's BIMS score was a 9/15. Resident R51's clinical record revealed progress notes dated 12/08/24, "PCP [physician] notified of residents suprapubic cath [catheter-a thin tube inserted through abdominal wall into bladder to drain urine] leaking and no output into Foley Bag [urine collection bag]. Abdominal pain noted at insertion site. PCP ordered to send the resident to ER [emergency room] for evaluation, EMS	F 0580		

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F 0580 SS=D	Continued from page 10 [Emergency Medical Services] contacted and dispatched to the facility, Resident will be sent to UPMC [University of Pittsburgh Medical Center]...." Resident R51's clinical record revealed a physician's order dated 12/20/24, Citalopram Hydrobromide (a drug that can treat depression and/or regulates mood and behavior) 10 milligram (mg) Give 0.5 tablet by mouth daily. Resident R51's clinical record lacked evidence that Resident R51's resident representative was notified of transfer to hospital on 12/08/24, or a new physician's order on 12/20/24, for Citalopram Hydrobromide. During an interview on 1/30/25, at 1:25 p.m. the Regional Clinical Consultant confirmed the facility lacked evidence that Resident R51's resident representative was notified for the above noted change in condition/transfer to hospital or new physician's order and that Resident R51's resident	F 0580		

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F 0580 SS=D	Continued from page 11 representative should have been timely notified. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.12 (d)(1)(5) Nursing services	F 0580		
F 0661 SS=E		F 0661		

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F 0661 SS=E	Continued from page 12 483.21(c)(2)(i)-(iv) Discharge Summary §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by:	F 0661	For residents CR82 a discharge summary was completed. All residents of the facility for the last 30days will be reviewed and a discharge summary will be completed. Licensed staff will be educated on discharge summary and the reconciliation of medications at the time of discharge and disposition of medications by the Director of Nursing/Designee An audit will be completed by the Director of Nursing/Designee for all residents who are being discharged from the facility prior to the resident being discharged to ensure that the resident's clinical record contains a discharge summary that includes a reconciliation of the resident's post-discharge medications. Audit will be weekly for 4 weeks then monthly ongoing. Findings will be reported to the Quality Assurance Performance Improvement committee for review and recommendations.	Completion Date: **03/28/2025** Status: **APPROVED** Date: **03/04/2025**

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F 0661 SS=E	Continued from page 13 Based on review of facility policy and clinical record, and staff interview, it was determined that the facility failed to include the recapitulation of stay (summary of resident's stay and course of treatment in the facility) that included a reconciliation of all pre-discharge medications with the resident's post-discharge medications for one of four closed record residents reviewed (Closed Record Resident CR82). Findings include: A facility policy entitled "Discharge Summary" dated 11/01/24, indicated that upon discharge of a resident a discharge summary will be provided to the receiving care provider at the time the resident leaves the facility. Resident CR82's clinical record revealed and admission date of 10/05/24, with diagnoses that included osteoarthritis of left knee (type of arthritis that occurs when flexible tissue at ends of bones in knee that wears down), pancytopenia (a blood	F 0661		

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F 0661 SS=E	Continued from page 14 disorder that occurs when the bone marrow does not form all three types of blood cells - red, white, and platelets), history of falling, and aortic valve stenosis (narrowing of the valve in the large blood vessel branching off the heart). Resident CR82's admission record indicated that Resident CR82 was discharged on 10/31/24, at 2:30 p.m. to home. Resident CR82's clinical record lacked documentation that the discharge summary included a reconciliation of all pre-discharge medications with the resident's post-discharge medications when Resident CR82 was discharged to home on 10/31/24. During an interview on 1/31/25, at 12:53 p.m. the Regional Clinical Consultant confirmed CR82's clincial record lacked documentation that the discharge summary included a reconciliation of all pre-discharge medications with the resident's post-discharge medications. 28 Pa. Code 201.14(a) Responsibility of Licensee	F 0661		

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GREENFIELD HEALTHCARE AND REHABILITATION CENTER STATE LICENSE NUMBER: **490802**	**1521 WEST 54TH STREET ERIE, PA 16509**

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F 0661 SS=E	Continued from page 15 28 Pa. Code 211.12(d)(1)(5) Nursing Services	F 0661		
F 0689 SS=D		F 0689		

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F 0689 SS=D	Continued from page 16 483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 0689	For residents R50 and all residents who will be admitted to the facility, a notice of non-smoking will be included in the admission packet and alternatives offered as the building is a non-smoking building. Admissions for the last 30 days were reviewed to ensure that they were notified of us being a nonsmoking facility by the administrator/designee Staff will be educated on non-smoking policy and reporting of smoking material in resident rooms by the Director of Nursing/designee No other residents have been reported to have smoking materials in their rooms at this time. An audit will be completed by social service/designee and will occur 3 times a week for 4 weeks, 2 times a week for 3 weeks, then weekly for 3 months to ensure that residents have signed the non-smoking policy and that residents with nicotine dependence do not have smoking materials in their possession.	Completion Date: **03/28/2025** Status: **APPROVED** Date: **03/04/2025**

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F 0689 SS=D	Continued from page 17	F 0689	Social Service will ask to be able to speak at Resident Council, to provide additional education regarding the facility non-smoking policy. The audit will be monitored by the Administrator and the results of the audit will be presented at the monthly Quality Assurance meeting and recommendations will be implemented.	

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F 0689 SS=D	Continued from page 18 Based on review of clinical records and facility policy, and resident and staff interviews, it was determined that the facility failed to assess and ensure safe smoking practices for one of 21 residents reviewed (Resident R50). Findings include: A facility policy entitled, "Resident Smoking/Nonsmoking Facility" dated 11/01/24, indicated that the facility will provide a safe and healthy environment for residents, visitors, and employees, including safety as related to smoking; smoking is prohibited; all residents and family members will be notified of this policy during the admission process, and as needed; and included electronic cigarettes. Resident R50's clinical record revealed an initial admission date of 4/12/22, with diagnoses that included nicotine dependence, respiratory failure, chronic obstructive pulmonary disease (lung disease causing restricted airflow and breathing problems),	F 0689		

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F 0689 SS=D	Continued from page 19 end-stage renal disease and dependence on dialysis (a procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly), and dependence on supplemental oxygen. Resident R50's clinical record included a care plan entitled "Resident is a smoker" initiated 10/24/23, with interventions including instruct resident about smoking risks, hazards, and about smoking cessation aids that ae available; monitor oral hygiene; nicotine gum as scheduled while awake (added 2/28/24), notify charge nurse immediately if it is suspected resident has violated facility smoking policy. Resident R50's clinical record included a care plan entitled "Resident had possession of nicotine substance not allowed on premises, history of smoking in resident bathroom" initiated 10/26/22, with interventions including: continue to attempt to transfer to facilities that allow smoking, per resident request (added 11/20/22), discuss coping strategies (added 10/26/22), instruct patient/visitors that	F 0689		

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F 0689 SS=D	Continued from page 20 nicotine products may not be brought onto the premises, resident will be checked upon return of leave of absence (added 10/26/22), offer Nicorette gum per physician's order (added 11/03/22), provide information on support groups or addiction treatment (added 10/26/22), psychological/psychiatric services as indicated/ordered (added 10/26/22), and routinely check on resident to ensure he/she is not smoking inside of facility (added 11/03/22). Further review of Resident R50's clinical record revealed a departmental progress note dated 12/23/24, that indicated Resident R50 was caught by staff smoking in his/her bathroom, staff educated Resident R50 about the facility policies and not smoking in the building and that the supervisor was informed of the incident. Resident R50's clinical record lacked evidence of documentation of confiscation of cigarettes and lighters, a smoking assessment, signed smoking policy agreement, and signed admission agreement.	F 0689		

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F 0689 SS=D	Continued from page 21 Observation on 1/29/25, at 12:55 p.m. of two light blue empty packs and three light blue opened partial packs of cigarettes and two lighters in Nursing Home Administrator's (NHA) office. During an interview at that time, the NHA confirmed the products belonged to Resident R50 and he/she has taken several packs of cigarettes and lighters from Resident R50 and told him/her that he/she can't smoke at the facility. During an interview on 1/29/25, at 1:09 p.m. Licensed Practical Nurse (LPN) Employee E1 confirmed that he/she had not witnessed Resident R50 smoking but had heard that he/she had been caught smoking. During an interview on 1/29/25, at 1:13 p.m. LPN Employee E2 confirmed that he/she had smelled the cigarette smoke and notified the supervisor, but never actually caught Resident R50 in the act of smoking.	F 0689		

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F 0689 SS=D	Continued from page 22 During an interview on 1/29/25, at 1:20 p.m. the Social Worker confirmed that on two occasions (prior to 12/23/24) he/she was asked to accompany the NHA to confiscate cigarettes and lighters from Resident R50 due to staff reported smelling smoke in the bathroom and that when Resident R50 was asked he/she volunteered cigarettes and lighters from under his/her wheelchair cushion. During an interview on 1/30/25, at 8:22 a.m. the NHA confirmed that there was no evidence of a signed admission agreement by Resident R50. During an interview on 1/30/25, at 8:36 a.m. the Social Worker confirmed that there was a no smoking policy in the Resident Handbook that is provided to residents/families on admission and believes the policy is provided on a case-by-case basis. During an interview on 1/30/25, at 9:30 a.m. Resident R50 confirmed that he/she didn't have any cigarettes/lighters at that time and has been offered	F 0689		

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F 0689 SS=D	Continued from page 23 alternatives but didn't like the way they made him/her feel. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(3)(1)(d) Management 28 Pa. Code 211.10(a)(d) Resident care policies	F 0689		
F 0695 SS=D		F 0695		

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F 0695 SS=D	Continued from page 24 483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by:	F 0695	Resident #27 orders were updated to contain CPAP and settings, and CPAP machine is functioning Resident #27 care plan was revised Resident # 50 oxygen concentrator filter was cleaned at time of findings. All residents with CPAPs were reviewed to ensure that they have physician orders and care plans for CPAP machines by the Director of Nursing/Designee All oxygen concentrators were checked to ensure filters were clean and in working order by the Director of Nursing/Designee Licensed staff to be educated on CPAP machines and obtaining orders for CPAP machines, updating the care plan, and maintenance of respiratory equipment by the Director of Nursing/Designee An audit will be conducted by the Director of Nursing/Designee to ensure that all residents with CPAPs were reviewed to ensure that they have physician orders and care plans for CPAP machines and all oxygen concentrators were checked	Completion Date: **03/28/2025** Status: **APPROVED** Date: **03/03/2025**

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F 0695 SS=D	Continued from page 25	F 0695	to ensure filters were clean and in working order. The audit will occur 3 times a week for 4 weeks, 2 times a week for 3 weeks then weekly ongoing. The audit will be monitored by the Administrator and findings will be reported to the Quality Assurance Meeting for review and recommendations.	

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F 0695 SS=D	Continued from page 26 Based on review of facility policies and clinical records, observations, and resident and staff interviews, it was determined that the facility failed to maintain proper care of respiratory equipment for two of 21 residents reviewed (Residents R27 and R50). Findings include: A facility policy entitled "Oxygen Concentrator" dated 11/01/24, indicated that the concentrator filters are cleaned weekly and that the main body cabinet should be dusted when needed and can be wiped down clean with a damp cloth and mild cleanser. A facility policy entitled "CPAP/BiPAP [continuous positive airway pressure/bilevel positive airway pressure] Support" dated 11/01/24, revealed the following: -Only a qualified and properly trained nurse or respiratory therapist should administer oxygen through a CPAP mask.	F 0695		

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F 0695 SS=D	Continued from page 27 -Review the resident's medical record to determine his/her baseline oxygen saturation or arterial blood gases (ABGs- measures the balance of oxygen and carbon dioxide in your blood to see how well your lungs are working), respiratory(organs that are involved in breathing), circulatory (delivers nutrients and oxygen to all cells in the body) and gastrointestinal (group of organs that work together to digest and absorb nutrients from the food you eat) status. -Review the physician's order to determine the oxygen concentration and flow for the machine. -General guidelines included: wipe machine with warm water at last once a week; clean humidifier chamber weekly; masks, nasal pillows, and tubing are cleaned daily and allowed to air dry; and wash headgear as needed and allow to dry. -Documentation includes general assessment before procedure, time machine was started and duration of therapy, mode and settings of the machine, oxygen concentration and flow, resident tolerance, and oxygen saturation during procedure. -Notify the physician if the resident refuses the	F 0695		

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F 0695 SS=D	Continued from page 28 procedure. Resident R27's clinical record revealed an admission date of 8/30/24, with diagnoses including obstructive sleep apnea (sleep disorder characterized by repeated episodes of complete or partial blockage of the upper airway during sleep), respiratory failure, heart failure, and obesity. The clinical record lacked a physician's order and/or care plan to apply a CPAP. An Inventory of Personal Effects revealed that Resident 27 brought a CPAP machine with him into the facility upon admission. Departmental progress notes revealed the following: On 12/05/24, at 2:04 p.m. that the facility notified the physician of abnormal carbon dioxide levels in Resident R27's lab results, and the physician responded to encourage Resident R27 to use the CPAP machine as ordered.	F 0695		

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F 0695 SS=D	Continued from page 29 On 12/08/24, at 1:38 a.m. that Resident R27 had fallen and that his/her oxygen saturation levels dropped into the 60%'s, and that staff applied the CPAP machine and Resident R27's oxygen saturation level rose into the 80%'s. On 12/18/24, at 9:09 a.m. that Resident R27 experienced a mental decline and that he/she was removing his/her supplemental oxygen and CPAP. On 12/18/24, at 2:24 p.m. Resident R27 was transferred to the hospital in respiratory distress due to staff not able to improve his/her oxygen saturations by using supplemental oxygen and the CPAP machine. On 1/02/25, at 5:50 p.m. Resident R27 reported chest pain, upon staff assessment he/she was offered the CPAP and Resident R27 responded "the ..... CPAP don't work", and that the Supervisor and Director of Nursing were both informed. Observations 1/28/25, at 2:02 p.m. revealed	F 0695		

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F 0695 SS=D	Continued from page 30 Resident R27's CPAP mask and tubing laying on the floor between the bed and nightstand, the humidifier chamber was empty, and the machine was not attached to the oxygen concentrator. During an interview at that time, Resident R27 confirmed that the mask and tubing have been laying on the floor, that no one has cleaned the machine because he/she can't use it because it doesn't attach to the oxygen concentrator he/she has now. Observation 1/29/25, at 11:05 a.m. revealed Resident R27's CPAP mask and tubing laying on the floor between the bed and nightstand, the humidifier chamber was empty, and the machine was not attached to the oxygen concentrator. During an interview on 1/30/25, at 2:40 p.m. Licensed Practical Nurse Employee E3 confirmed the CPAP mask and tubing were on the floor, that the CPAP machine was Resident R27's personal machine from home, and that he/she didn't believe that it can be hooked up to the concentrator.	F 0695		

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F 0695 SS=D	Continued from page 31 During an interview on 1/30/25, at 4:03 p.m. the Nursing Home Administrator confirmed there was no physician's order, care plan, or documentation of the necessary CPAP machine settings in Resident R27's clinical record. Resident R50's clinical record revealed an initial admission date of 4/12/22, with diagnoses that included nicotine dependence, respiratory failure, chronic obstructive pulmonary disease (lung disease causing restricted airflow and breathing problems), end-stage renal disease and dependence on dialysis (a procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly), and dependence on supplemental oxygen. Resident R50's clinical record revealed a physician's order dated 1/24/25, to clean oxygen concentrator filter, change all oxygen tubing, change nebulizer tubing if in use every Friday. Observations on 1/28/25, at 3:00 p.m. and 1/29/25,	F 0695		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0695 SS=D	Continued from page 32 at 11:30 a.m. revealed Resident R50's oxygen concentrator filter was covered in a thick layer of greyish white, fluffy substance. During an interview on 1/30/25, at 1:35 p.m. the Assistant Director of Nursing confirmed the oxygen concentrator filter was covered in a thick layer of greyish white, fluffy substance. 28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services	F 0695		
F 0698 SS=D		F 0698		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395262	A. BLDG: 00 B. WING:	02/04/2025

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F 0698 SS=D	Continued from page 33 483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by:	F 0698	Resident #50 Dialysis Communication book will be sent with resident on dialysis days. All residents receiving dialysis will have a dialysis communication book go with them to dialysis. Licensed staff will be educated on dialysis communication book and review of documents in book by the Director of Nursing/Designee Audit for all residents who are on dialysis will be conducted by the Director of Nursing/Designee weekly for 4 weeks to ensure that dialysis and the facility are communicating via communication book and the monthly ongoing Findings will be reported to the Quality Assurance Performance Improvement committee for review and recommendations.	Completion Date: **03/28/2025** Status: **APPROVED** Date: **03/03/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0698 SS=D	Continued from page 34 Based on review of the facility documents and clinical records, and resident and staff interview, it was determined that the facility failed to maintain complete and accurate records relating to dialysis communication for one of 21 residents reviewed (Resident R50). Findings include: The Nursing Home Dialysis Transfer Agreement signed on 1/02/25, revealed that the facility shall ensure that all appropriate medical, social, administrative, and other information accompany all Designated Residents at the time of transfer to the center, and that the facility will provide for the interchange of information useful or necessary for the care of the Designated Resident and will inform the Center of a contact person at the Facility whose responsibilities include oversight of provision of dialysis services by Center to the Designated Residents of Facility. Resident R50's clinical record revealed an initial	F 0698		

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F 0698 SS=D	Continued from page 35 admission date of 4/12/22, with diagnoses that included nicotine dependence, respiratory failure, chronic obstructive pulmonary disease (lung disease causing restricted airflow and breathing problems), end-stage renal disease and dependence on dialysis (a procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly), and dependence on supplemental oxygen. The clinical record also revealed a current physician's order dated 1/24/25, to send Resident R50 to dialysis center on Monday, Wednesday, and Friday for an 11:00 a.m. chair time. Review on 1/30/25, at 5:00 p.m. of Resident R50's designated dialysis book (kept in his/her room) revealed that it contained Dialysis Communication Forms dated 1/15/25, 12/24/24, 12/22/24, 11/18/24, 11/15/24, 11/13/24, 11/11/24, 1/04/24, 10/28/24, 10/11/24, 10/09/24, 10/07/24, 10/04/24, and 9/27/24. During an interview at that time, Resident R50 confirmed that staff from the facility don't ask to see	F 0698		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0698 SS=D	Continued from page 36 it and it depends on who's working at the dialysis center. During an interview on 1/30/25, at 6:30 p.m. the Nursing Home Administrator confirmed that Resident R50's dialysis book was missing several Dialysis Communication Forms and the forms in the book were not current. 28 Pa. Code 211.5(f)(viii) Medical Records 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services	F 0698		
F 0725 SS=E		F 0725		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0725 SS=E	Continued from page 37 483.35(a)(1)(2) Sufficient Nursing Staff §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by:	F 0725	All nursing staff are to be educated on resident rights, the cell phone policy, use of earbuds and answering call bells timely, by the Director of Nursing/Designee Administrator will meet with the President/Vice President of Resident Council monthly to ask if they can attend Resident Council, to discuss if staff is answering call lights, completing incontinence care, and refraining from the use of cell phones and earbuds. Results of the discussion will be documented. An audit will be conducted to ensure staff are meeting residents' needs timely by the director of nursing/designee to include answering of call lights, incontinent care, and use of cell phones and earbuds by staff. The audit will be conducted by the DON/Designee by interviewing 3 residents per unit per shift 3 times a week for 4 weeks, weekly for 4 weeks and then 1 time per month ongoing. The audit will be monitored by the Administrator and results will be	Completion Date: **03/28/2025** Status: **APPROVED** Date: **03/03/2025**

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F 0725 SS=E	Continued from page 38	F 0725	reported to the Quality Assurance Performance Improvement committee for review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0725 SS=E	Continued from page 39 Based on resident interviews and observations, it was determined that the facility failed to provide sufficient nursing staff to promote the physical and mental well-being and meet the needs of seven of 21 residents interviewed (Residents R2, R55, R34, R6, R186, R68, R36, R2, R41, and R19). Findings include: Interviews during the Resident Council meeting on 1/29/25, between 1:00 p.m. and 1:45 p.m., revealed seven out of seven alert and oriented residents in attendance had concerns related to staff not responding to their call bells timely. Resident R68 indicated that it could take 45 minutes or more for his/her call bell to be answered and staff are observed on their phones and occasionally have earbuds in and talking on the phone when performing care. Resident R68 stated that he/she is left wet for long periods of time waiting for assistance. Resident R68 also disclosed that on weekends there is no use asking to get out of bed, because you will wait all day for assistance to get	F 0725		

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F 0725 SS=E	Continued from page 40 back in bed. Resident R6 indicated that he/she will wait for 30 minutes to an hour to recieve care or assistance with the call bell once turning it on. Resident R2 agreed that he/she observes and witnesses long call bell waits and employees constantly on their phones and talking to significant others on the phone or performing care with ear buds in. Residents R55, R34, R186, and R36 indicated they wait 30 minutes or longer when their call bell is turned on to be responded to by staff. During an interview on 1/28/25, at 2:25 p.m. Resident R2 revealed he/she was frustrated that it takes over an hour for his/her call bell to be responded to by staff. Resident R2 further indicated that staff are always sitting at the desk on their phones or in the hallways with their phones; sometimes, the staff will even be on their phones when they are in the residents' rooms. During an interview on 1/28/25, at 2:30 p.m. Resident R68 revealed that his/her call bell can be on for an hour easily and even more on the	F 0725		

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F 0725 SS=E	Continued from page 41 weekends. Resident R68 verbalized, "I will not get out of bed on the weekends due to being left in my chair then for way too long. One weekend, I was left in my wheelchair for nine hours. I was in so much pain and I was totally soaked." An observation on 1/29/25, at 10:25 a.m. revealed a call light on for Room 233. The call light continued on for a period of 30 minutes and during that time, the Director of Nursing (DON) was requested to address the call light at 10:55 a.m. Resident R41 indicated that it was his/her call bell on for past 30 minutes and that he/she was incontinent and needed changed. The DON confirmed that 30 minutes was too long for a resident to have to wait for their call bell to be answered, being left incontinent and at risk for skin breakdown. During observation of a dressing change of Resident R19 on 1/30/2025, at about 10:30 a.m. it was observed upon preparing the resident for the dressing change that Resident R19 was lying in bed dressed with an adult undergarment on wet with	F 0725		

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	395262	A. BLDG: __00_____ B. WING: _____	02/04/2025

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GREENFIELD HEALTHCARE AND REHABILITATION CENTER	**1521 WEST 54TH STREET ERIE, PA 16509**
STATE LICENSE NUMBER: **490802**	

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F 0725 SS=E	Continued from page 42 urine and soaked through to the bed pad and bed sheets. Licensed Practical Nurse (LPN) Employee E4 was observed and cleaned and changed the resident prior to performing the dressing change. LPN Employee E4 confirmed that Resident R19 was lying in bed in urine for an extended period of time. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.12(d)(4)(5) Nursing services	F 0725		
F 0732 SS=C		F 0732		

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F 0732 SS=C	Continued from page 43 483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.	F 0732	Nursing staffing was posted at time of finding Nursing staff were educated on posting of staffing for the day which included the required components by the Director of Nursing/designee Nurse staffing will be posted by midnight registered nurse in the main common area and each unit Audit will be conducted 5 times a week by the Director of Nursing/Designee to ensure that the nursing staffing is posted daily by the Director of Nursing/designee Findings will be reported to the Quality Assurance Performance Improvement committee for review and recommendations.	Completion Date: **03/28/2025** Status: **APPROVED** Date: **03/03/2025**

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	395262	A. BLDG: __00_____ B. WING: _____	02/04/2025

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STATE LICENSE NUMBER: **490802**	

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F 0732 SS=C	Continued from page 44 §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by:	F 0732		

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F 0732 SS=C	Continued from page 45 Based on observations and staff interview, it was determined that the facility failed to ensure that the required nursing staffing information was posted on a daily basis. Findings include: Observations on 1/28/25, at 1:00 p.m., 1/29/25, at 9:00 a.m., and 1/30/25, at 1:00 p.m. revealed that the daily staffing posting was not posted in the facility. During an interview on 1/30/25, at 1:10 p.m. the Nursing Home Administrator, confirmed that the staffing was not posted as required. 28 Pa. Code 211.12 (c) Nursing services	F 0732		
F 0755 SS=D		F 0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0755 SS=D	Continued from page 46 483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 0755	R234 received medication from the pharmacy that evening. Residents with medications that require a script were reviewed to ensure medication was on hand by the Director of Nursing/designee. Licensed staff were educated on use of emergency medication kit and process to obtain authorization to pull a controlled substance and who to contact if having difficulty by the Director of Nursing/Designee An audit will be conducted on new admissions and 8 other residents 3 times a week for 4 weeks to ensure controlled substances are provided timely by the pharmacy or a pull code was obtained timely by the director of nursing/designee then weekly for 4 weeks then monthly ongoing. Findings will be reported to the Quality Assurance Performance Improvement committee for review and recommendations.	Completion Date: **03/28/2025** Status: **APPROVED** Date: **03/03/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395262	A. BLDG: __00_____ B. WING: _____	02/04/2025

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STATE LICENSE NUMBER: **490802**	

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F 0755 SS=D	Continued from page 47 This REQUIREMENT is not met as evidenced by:	F 0755		

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GREENFIELD HEALTHCARE AND REHABILITATION CENTER STATE LICENSE NUMBER: **490802**	**1521 WEST 54TH STREET ERIE, PA 16509**

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F 0755 SS=D	Continued from page 48 Based on review of clinical and facility records, and resident and staff interviews, it was determined that the facility failed to ensure medications were administered, whether prescribed on a routine, emergency, or as needed basis, to not impede timely administration and adversely affect a resident's condition for one of 21 residents reviewed (Resident R234). Findings include: Facility pharmacy policy, "Specialty Rx, Inc. PA ADS [Automated Dispensing System] Station Medication Policies and Procedures," dated 11/01/24, revealed "Nursing and Pharmacy will use the ADS Station as an inventory, charging and information system for the control and distribution of medications for Emergency, First-Dose use and other situations where medications are not available from pharmacy. (NOT TO BE USED FOR CONTINUOUS DOSING). Emergency doses for narcotic medications removed from the ADS system will require a written order from a prescriber (order	F 0755		

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	395262	A. BLDG: 00 B. WING:	02/04/2025

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F 0755 SS=D	Continued from page 49 should include that medication can be taken from the ADS) and would require signature within 48 hours per regulations. The facility must contact the pharmacy and obtain an authorization code for removal of any controlled substance. An authorization code can only be given if the pharmacy has a script on file with quantity remaining matching the controlled substance the facility wishes to remove. If there is no script on file, the pharmacist will page the prescriber for an electronic prescription or an emergency supply." Facility provided report on 1/31/25, by the Nursing Home Administrator (NHA) entitled "Inventory on Hand, C11" revealed Hydroco/APAP Tab 5-325 mg as medication available in the emergency ADS Station supply within the facility for resident emergency, first dose, and other situations where medications are not available from the pharmacy. Resident R234's "Admission Record" revealed an admission date of 1/19/25, with diagnoses that included Parkinson's disease (a disorder of the	F 0755		

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F 0755 SS=D	Continued from page 50 central nervous system that affects movement), cardiac arrythmias (improper beating of the heart, whether irregular, too fast or too slow), bipolar disorder (a mental health condition that affects mood swings ranging from depressive lows to maniac highs), and dysphagia (difficulty swallowing foods or liquids). Resident R234's clinical record revealed progress notes dated 1/25/25, at 5:01 p.m. that Resident complained of pain this shift. Resident family (brother) called facility asked for pain medication for Resident R234. Facility nurse looked in resident orders to find resident has only prn (as needed) Tylenol ordered at this time for pain. Facility nurse called Nurse Practitioner (NP). New order for Norco 5 milligrams (mg) Q (every) 12 Hrs P.O. (by mouth) E-script (electronic medication prescription). NP sent E-scripts to pharmacy. This author called pharmacy and asked to be given a pull code for E-kit (emergency medication kit). Pharmacist stated no because "I have already packed up the medication and it will be leaving here in about 20	F 0755		

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F 0755 SS=D	Continued from page 51 minutes." Facility nurse stated to pharmacist "I believe you maybe 5-6 hours away, and resident already have had to wait this long." Pharmacist stated, "well I cannot unwrap medication from delivery stock." Facility nurse stated "ok." Facility nurse notified nursing supervisor, RN. This author then called DON (Director of Nursing), because he/she was here in his/her office to see if he/she could talk with pharmacy about Resident R234's medication. Awaiting outcome. Resident R234's clinical record revealed his/her Medication Administration Record (MAR) dated 1/25/25, for a physician order Hydrocodone-Acetaminophen oral tablet 5-325 mg (Hydrocodone-Acetaminophen) Give one tablet by mouth every 12 hours as needed for Pain-Moderate with a start date 1/25/25, 3:00 p.m. and discontinue date date 1/27/25, at 12:01 p.m.. Resident R234's MAR further revealed that Resident R234 was administered the first dose of Hydrocodone-Acetaminophen 5-325 mg oral tablet at 11:09 p.m. on 1/25/25.	F 0755		

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F 0755 SS=D	Continued from page 52 During an interview with Resident R234 on 1/28/25, at 1:30 p.m. he/she indicated the facility did not ensure he/she was medicated for pain. Resident R234 further indicated he/she had to wait a long time for pain medication, even when it was finally ordered by the physician on 1/25/25, it took several hours to actually get it. Resident R234 indicated that he/she had discomfort with leg and back cramps related to Parkinson's disease. During an interview on 1/31/25, at 8:55 a.m. the NHA confirmed that the Hydrocodone-Acetaminophen 5-325 mg medication was available in the emergency medication stock in the facility and Resident R234 should have been administered the medication at 5:01 p.m. on 1/25/25, per the physician's order. The NHA further confirmed that the pharmacist failed to further communicate with the physician the need for a further script for a one-time dose, since he/she would not provide the facility nurse an authorization code from the initial script for the Hydrocodone	F 0755		

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F 0755 SS=D	Continued from page 53 Acetaminophen 5-325 mg medication at 5:01 p.m. 1/25/25, delaying the acquisition of a medication and impeding the timely administration to help with Resident R234's pain. 28 Pa. Code 211.9(a)(1)(d)(l)(4) Pharmacy services 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services	F 0755		
F 0761 SS=D		F 0761		

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STATE LICENSE NUMBER: **490802**	

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F 0761 SS=D	Continued from page 54 483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 0761	The Vial was discarded at the time of finding. All medication areas were checked at the time of survey All licensed staff were educated by the Director of Nursing/designee on multidose vial policy. An audit will be conducted weekly to ensure vaccine vials are dated with date open for 4 weeks then monthly ongoing by the Director of Nursing/designee on all units including med room and carts. Findings will be reported to the Quality Assurance Performance Improvement committee for review and recommendations.	Completion Date: **03/28/2025** Status: **APPROVED** Date: **03/03/2025**

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F 0761 SS=D	Continued from page 55 Based on review of Centers for Disease Control (CDC) vaccine guidance, facility policy, observation, and staff interview, it was determined that the facility failed to safely store medications in one of two medication rooms observed (East Wing). Findings include: A facility policy entitled "Multi-Dose Vials (contain more than one dose of medication)" dated 11/01/24, indicated that when a multiple dose vial is opened it shall be labeled with date open, medications will be discarded as per manufacturer guidelines for vaccines. Observation on 1/30/25, at 11:44 a.m. of the East Wing medication room revealed a multi-dose vial of Flucelvax (vaccine that protects against the flu) was opened, lacked an opened date, and lacked guidance related to discarding opened vials. During an interview at that time the Assistant	F 0761		

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F 0761 SS=D	Continued from page 56 Director of Nursing confirmed that the multi-dose vial lacked an open date, and that staff cannot tell when the vaccine should be discarded. Review of the CDC web site revealed that the guidance for opened multi-dose vials is to discard 28 days after opening. On 1/30/25, at 12:07 p.m. information obtained by the facility from the dispensing pharmacy confirmed pharmacy indicated the multi-dose vial would be expired 28 days after opening. 28 Pa. Code 211.9(a)(1) Pharmacy services 28 Pa. Code 211.12(d)(1)(5) Nursing Services	F 0761		
F 0791 SS=E		F 0791		

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F 0791 SS=E	Continued from page 57 483.55(b)(1)-(5) Routine/Emergency Dental Srvcs in NFs §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(f) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay;	F 0791	Resident #51 appointment was made by administrator/designee Resident # 187 is no longer a resident at the facility. All residents were reviewed to ensure that their dental needs are met by the Director of Nursing or designee which included missing dentures and dental needs. Social Service and nursing staff were educated on the Care of dentures policy and making appointments in timely manner by the Director of Nursing/designee Audit will be conducted weekly for 4 weeks and then monthly ongoing to ensure that residents that required dental care to meet their needs this includes with residents that have missing or ill fitting dentures will be addressed as per policy by the Director of Nursing/Designee 5 Residents will be interviewed weekly by Social services or designee to ensure dental concerns are being addressed weekly for 4 weeks then	Completion Date: **03/28/2025** Status: **APPROVED** Date: **03/04/2025**

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F 0791 SS=E	Continued from page 58 §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by:	F 0791	monthly ongoing Findings will be reported to the Quality Assurance Performance Improvement committee for review and recommendations.	

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F 0791 SS=E	Continued from page 59 Based on review of clinical and facility records, observation, and resident and staff interviews, it was determined that the facility failed to ensure the use of dentures for two of 21 residents reviewed (Residents R51 and R187). Findings include: Review of a facility policy entitled, "Care of Dentures" with an annual review date of 11/01/2024, revealed Dentures that are missing, damaged, or lost and the facility or facility are at fault, a referral will be made promptly within three days. Facility responsibilities include dropped, stolen, and/or broken by our employees. facility is not responsible for the resident discarding themselves or ill fitting dentures or partials at admission. Facility will assist resident/responsible party with non-facility related denture issues. Resident's R51's clinical record revealed an admission date of 3/23/22 with diagnoses that included multiple sclerosis (a disease in which the	F 0791		

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F 0791 SS=E	Continued from page 60 immune system destroys the protective covering of nerves resulting in nerve damage disrupting communication between body and brain), Alzheimer's disease (a disease of the brain resulting in mood and behavioral changes and poor decision making), neuromuscular dysfunction of the bladder (a condition where the nerves controlling bladder function are damaged), and muscle weakness. Resident R51's "Inventory of Personal Effects" dated 3/23/22, indicated the resident had upper and lower dentures. Resident R51's "360 Care of Pennsylvania" Dental provider log revealed on 12/18/24, he/she was evaluated by the dentist. A description of the dental visit dated 12/18/24, revealed "Exam Medical History - reviewed, Patient presents for periodic exam. Patient is edentulous has upper and lower denture. Denture(s) fit well and patient is satisfied." Resident R51's dental care plan dated 11/06/24, indicated Resident 51 required assistance with oral	F 0791		

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F 0791 SS=E	Continued from page 61 hygiene and to wear his/her dentures, and nursing staff are to report changes in oral cavity, chewing ability, signs and symptoms or oral pain, etc. An interview with Resident R51 on 1/29/25, at 1:00 p.m. revealed that he/she was missing his/her upper dentures. Resident R18 verbalized, "Oh I would like to have my dentures. I need them." An interview with the Nursing Home Administrator (NHA) on 1/30/25, at 11:00 a.m. confirmed that Resident R51 did not have his/her upper and lower dentures, and no investigation or follow-up process had been initiated by the facility to replace the dentures. Resident's R187's clinical record revealed an admission date of 7/7/23 with diagnoses that included cerebral infarction (a condition in which blood flow to the brain is interrupted, causing brain tissue to die), sjogren syndrome (an immune system illness that mainly causes dry eyes and mouth), vascular dementia with mood disturbance	F 0791		

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F 0791 SS=E	Continued from page 62 (experiencing mood changes such as depression, anxiety, depression, or apathy related to having dementia), and brief psychotic disorder. Resident R187's "Inventory of Personal Effects" dated 7/7/23, indicated the resident had one upper partial upon admission. An evaluation of speech sound production and language assessment on 7/10/23, revealed that upon a general, facial, and mandibular assessment: Oral Motor Function = WFL (for mechanical soft chopped food items. Resident has upper partial that she removes from oral cavity and does not always wear during oral intake). A social services progress note dated 7/11/23, at 8:57 a.m. revealed, "Concern that upper partial is missing since Sunday 7/9, last seen Sat 7/8 in denture cup. Discussed dietary preferences No coffee/tea/milk, No eggs, enjoys orange juice, ice water and ginger ale. Resident does not like sandwiches nut enjoys fish, chicken, noodles, rice,	F 0791		

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F 0791 SS=E	Continued from page 63 vegetables and bananas." A progress note from 7/12/23, at 9:31 a.m. revealed "observed a denture cup in the garbage can in res room. Looked through garbage can, in nightstand, dresser, in pockets of clothing items, in bathroom medicine cabinet; did not see partial. Res does not recall wearing partial. Partial not in residents mouth. Notified nursing of the above. LPN reported that clothing items were removed from res garbage can in the previous days. Nursing, Social services, DON [Director of Nursing], ADON [Assistant Director of Nursing] and Administrator notified." An interview with the Nursing Home Administrator (NHA) on 1/30/25, at about 3:00 p.m., confirmed that Resident R187 did have an upper partial upon being admitted to the facility on 7/7/23, according to the inventory sheet. They did go missing according to documentation record, and no evidence of an investigation or follow-up process had been initiated by the facility to replace the dentures.	F 0791		

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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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STATE LICENSE NUMBER: **490802**	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0791 SS=E	Continued from page 64 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 201.29(a) Resident rights	F 0791		
F 0880 SS=D		F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395262	A. BLDG: 00 B. WING:	02/04/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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F 0880 SS=D	Continued from page 65 483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 0880	Resident # 14 bag was removed from the floor at the time of findings Residents were reviewed to ensure foley catheter bags were properly placed and covered. Nursing staff will be educated on Catheter care policy and the need to ensure foley bag and tubing is not touching the floor by the Director of Nursing/Designee Audit will be conducted 3 times a week for 4 weeks to ensure that foley bags are not on the ground and covered for all residents with foleys then weekly for 4 weeks then monthly ongoing by Director of Nursing/designee Foley bags have built in covers Findings will be reported to the Quality Assurance Performance Improvement committee for review and recommendations.	Completion Date: **03/28/2025** Status: **APPROVED** Date: **03/04/2025**

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F 0880 SS=D	Continued from page 66 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 0880		

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F 0880 SS=D	Continued from page 67	F 0880		

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F 0880 SS=D	Continued from page 68 Based on review of facility and clinical records, observations, and staff and resident representative interviews, it was determined the facility failed to ensure that residents with an indwelling catheter (a tube inserted into the bladder to facilitate urine drainage) receive essential care for one of 21 residents reviewed with indwelling catheters (Resident R14). Findings include: Facility policy entitiled, "Catheter Care" dated 11/01/24, revealed it is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care and maintain their dignity and privacy when indwelling catheters are in use. Privacy bags will be available and catheter drainage bags will be covered at all times while in use. Ensure drainage bag is located below the level of the bladder to discourage backflow of urine and not to be located on the floor. Resident R14's clinical record revealed an admission	F 0880		

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F 0880 SS=D	Continued from page 69 date of 9/25/20, with diagnoses that included osteomyelitis of vertebra, sacral, and sacrococcygeal region (inflammation of bones of lower spine caused by infection), paraplegia (impairment or loss of motor and sensory functions of both legs), absence of left leg above knee, and protein-calorie malnutrition (a condition when the body does not receive enough protein through diet). Observation on 1/28/25, at 1:55 p.m., revealed Resident R14's catheter tubing stretched out with the drainage bag laying in the center of the floor beside the left of bed. Resident R14 indicated at this time, that he/she did not place the bag on the floor, but staff would be in to empty the catheter bag. Observation on 1/29/25, at 1:00 p.m., revealed Resident R14's catheter drainage bag laying on the floor beside the left of bed. Observation on 1/30/25, at 3:05 p.m., revealed Resident R14's catheter drainage bag uncovered and laying on the floor beside the left of bed.	F 0880		

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F 0880 SS=D	Continued from page 70 An interview with Licensed Practical Nurse (LPN) Employee E1 on 1/30/25, at 3:05 p.m. confirmed that Resident R14's foley catheter bag was observed laying on the floor. LPN Employee E1 further confirmed the foley catheter should be covered and maintained off the floor for dignity and infection control measures to prevent an infection. An interview with the Nursing Home Administrator on 1/30/25, at 5:00 p.m. confirmed that Resident R14's foley catheter bag should be covered to ensure dignity and be maintained off the floor and/or not touch an unclean surface due to risk for infection. 28 Pa. Code 211.12 (d)(1)(2)(3)(5) Nursing services	F 0880		
F 0947 SS=F		F 0947		

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F 0947 SS=F	Continued from page 71 483.95(g)(1)-(4) Required In-Service Training for Nurse Aides §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.71 and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by:	F 0947	Review of Nurse Aides personnel files was conducted to ensure that they have 12 hour in servicing All nurse aides that did not have evidence of completing the 12 hour in-service will receive 12 hour Inservice training by the Director of Nursing/Designee and completed by 3/28/25 Audit will be conducted weekly to ensure nurse aides requiring the 12-hour training within the last year have received the training for 4 weeks then monthly audit will be of 5 nurse aides per week by the administrator/designee Findings will be reported to the Quality Assurance Performance Improvement committee for review and recommendations.	Completion Date: **03/28/2025** Status: **APPROVED** Date: **03/03/2025**

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F 0947 SS=F	Continued from page 72 Based on review of facility employee in-service training records and staff interview, it was determined that the facility failed to assure that staff completed all the required mandatory trainings for the yearly Nurse Aide (NA) 12-hour mandatory trainings. Findings include: Review of requested records or evidence of in-service mandatory training for all NA's from 1/2024 through 1/2025 was incomplete upon review. The facility was unable to provide complete evidence of completed competencies the the past year. During an interview on 1/31/25, at 2:30 p.m. the Nursing Home Administrator confirmed that no evidence could be provided of NA's 12-hour mandatory in-service trainings as required. 28 Pa. Code 211.12(d)(3)(5) Nursing services	F 0947		

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F 0947 SS=F	Continued from page 73 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 201.19(7) Personnel policies and procedures	F 0947		

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P 4810	Procedure in event of death. (a) Written postmortem procedures shall be available to all personnel. This REGULATION is not met as evidenced by:	P 4810	Licensed staff will have access to the facility postmortem procedures that are located at the nurse's station and will be educated on postmortem care by the Director of Nursing/Designee. An audit will be conducted by the Director of Nursing/Designee weekly for 4 weeks of all deceased residents who cease to breath each week to ensure residents receive postmortem care process and appropriate documentation and observations will occur using clinical documentation review and observation and interview of 3 staff members regarding the knowledge of the facility post mortem care policy and then monthly for 4 months. Findings will be reported to the Quality Assurance Performance Improvement committee for review and recommendations.	Completion Date: **03/28/2025** Status: **APPROVED** Date: **03/06/2025**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE:	(X6) DATE:

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P 4810	Continued from page 1 Based on review of clinical records, and staff interview, it was determined that the facility failed to ensure written postmortem procedures shall be available to all personnel for one of four closed records reviewed (Closed Record Resident CR81). Findings include: No facility policy provided. Resident CR81's clinical record revealed and admission date of 10/29/22, with diagnoses that included metabolic encephalopathy (a condition where the brain does not function properly due to an underlying chemical imbalance), bactremia (a bloodstream infection), urinary tract infection, and severe protein calorie malnutrition (a condition when the body does not receive enough protein through the diet). Progress notes dated 11/15/24, indicated that Resident CR81 had ceased to breathe on 11/15/24.	P 4810		

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P 4810	Continued from page 2 Resident CR81's clinical record lacked documentation of the postmortem procedures when the Resident CR81 ceased to breathe on 11/15/24. During an interview on 1/31/25, at 12:53 p.m. the Regional Clinical Consultant confirmed Resident CR81's clinical record lacked documentation of the postmortem procedures when Resident CR81 ceased to breathe on 11/15/24.	P 4810		
P 4880		P 4880		

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P 4880	Continued from page 3 Medical records. (f) In addition to the items required under 42 CFR 483.70(i)(5) (relating to administration), a resident ' s medical record shall include at a minimum: (i) Physicians' orders. (ii) Observation and progress notes. (iii) Nurses' notes. (iv) Medical and nursing history and physical examination reports. (v) Admission data. (vi) Hospital diagnoses authentication. (vii) Report from attending physician or transfer form. (vii) Diagnostic and therapeutic orders. (viii) Reports of treatments. (ix) Clinical findings. (x) Medication records. (xi) Discharge summary, including final diagnosis and prognosis or cause of death. This REGULATION is not met as evidenced by:	P 4880	Resident # 81 and # 83 recapitulation was completed Residents discharged and or ceased to breathe within the last 15 days will be reviewed for recapitulation of stay and will be completed The Intradisciplinary team will be educated on the recapitulation of stay that is to be completed for any discharged or ceased to breathe by the Administrator An audit will be conducted on residents that all discharged or ceased to breathe weekly for 4 weeks then monthly by the Administrator to ensure a recapitulation of stay is completed Findings will be reported to the Quality Assurance Performance Improvement committee for review and recommendations.	Completion Date: **03/28/2025** Status: **APPROVED** Date: **03/03/2025**

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P 4880	Continued from page 4 Based on review of clinical records and staff interview, it was determined that the facility failed to include the recapitulation of stay (summary of residents stay and course of treatment in the facility) for two of four closed records reviewed (Closed Record Residents CR81 and CR83). Findings include: Resident CR81's clinical record revealed and admission date of 10/29/22, with diagnoses that included metabolic encephalopathy (a condition where the brain does not function properly due to an underlying chemical imbalance), bactremia (a bloodstream infection), urinary tract infection, and severe protein calorie malnutrition (a condition when the body does not receive enough protein through the diet). Progress notes dated 11/15/24, indicated that Resident CR81 had ceased to breathe on 11/15/24. Review of Resident CR81's clinical record lacked evidence of a recapitulation of Resident CR81's stay	P 4880		

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P 4880	Continued from page 5 at the facility. Resident CR83's clinical record revealed and admission date of 4/10/24, with diagnoses that included diabetic ulcers of both feet, end-stage renal disease and dependence on dialysis (procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly), Type 2 Diabetes (condition that happens because of a problem in the way the body regulates and uses sugar as a fuel), and peripheral vascular disease (condition where the blood vessels outside the heart and brain become narrowed or blocked, reducing blood flow to the limbs). A departmental progress note dated 11/10/24, indicated that he/she had been transported to the acute hospital for evaluation and Resident CR83's record revealed that he/she had not returned to the facility. Review of Resident CR83's clinical record lacked evidence of a recapitulation of Resident CR83's stay at the facility.	P 4880		

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P 4880	Continued from page 6 During an interview on 1/31/25, at 12:53 p.m. the Regional Clinical Consultant confirmed Residents CR81 and CR83 clinical records lacked evidence of a recapitulation of his/her stay at the facility.	P 4880		
P 5280		P 5280		

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P 5280	Continued from page 7 Pharmacy services. (j.1) The facility shall have written policies and procedures for the disposition of medications that address all of the following: (1) Timely and safe identification and removal of medications for disposition. (2) Identification of storage methods for medications awaiting final disposition. (3) Control and accountability of medications awaiting final disposition consistent with standards of practice. (4) Documentation of actual disposition of medications to include the name of the individual disposing of the medication, the name of the resident, the name of the medication, the strength of the medication, the prescription number if applicable, the quantity of medication and the date of disposition. (5) A method of disposition to prevent diversion or accidental exposure consistent with applicable Federal and State requirements, local ordinances and standards of practice. This REGULATION is not met as evidenced by:	P 5280	Resident CR 81, CR 82, CR 83, we were unable to complete a disposition of medications. Residents that were discharged for the last 30 days were for disposition of medications but unable to complete a disposition of medications Residents discharged, transferred, or ceased to breathe will have a disposition of medication completed Licensed staff were educated on the disposition of medication policy by the Director of Nursing/designee Audit will be conducted for those residents who were discharged, transferred, or ceased to breathe weekly for 4 weeks to ensure that disposition of medication on all residents are completed by the Director of Nursing/Designee then monthly for 2 months Findings will be reported to the Quality Assurance Performance Improvement committee for review and recommendations.	Completion Date: **03/28/2025** Status: **APPROVED** Date: **03/04/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395262	A. BLDG: 00 B. WING:	02/04/2025

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P 5280	Continued from page 8 Based on review of facility policy and clinical records, and staff interview, it was determined that the facility failed to document the actual disposition of medications for three of four closed records reviewed (Closed Record Residents CR81, CR82, and CR83). Findings include: A facility policy entitled, "Medication Disposition" dated 11/01/24, revealed the following: 1. That unless otherwise prohibited under applicable federal or state laws, individual resident medication supplied in sealed unopened containers my be returned to the issuing pharmacy for disposition provided that: all such medication are identified as to lot or control number: the receiving pharmacist and a registered facility nurse sign a separate log that lists the resident's name; the name, strength, prescription number (if applicable), amount of the medication, and the date the medication was returned.	P 5280		

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P 5280	Continued from page 9 2. Medications that cannot be returned to the dispensing pharmacy are disposed of in accordance with federal, state, and local regulations; the medication disposition record contains, as a minimum; resident's name, name and strength of medication, prescription number (if any), name of dispensing pharmacy, date medication destroyed, quantity destroyed, method of destruction, and signature of witnesses; the completed medication disposition records are kept on file in the facility for at least two years. Resident CR81's clinical record revealed and admission date of 10/29/22, with diagnoses that included metabolic encephalopathy (a condition where the brain does not function properly due to an underlying chemical imbalance), bacteremia (a bloodstream infection), urinary tract infection, and severe protein calorie malnutrition (a condition when the body does not receive enough protein through the diet). Progress notes dated 11/15/24, indicated that Resident CR81 had ceased to breathe on	P 5280		

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P 5280	Continued from page 10 11/15/24. Resident CR81's clinical record lacked documentation of the actual disposition of medications to include the name of the staff disposing of the medication, resident's name, medication name, strength of the medication, the prescription number (if applicable), the quantity of medication, method of disposition, and the date of disposition when Resident CR81 ceased to breathe on 11/15/24. Resident CR82's clinical record revealed and admission date of 10/05/24, with diagnoses that included osteoarthritis of left knee (type of arthritis that occurs when flexible tissue at ends of bones in knee that wears down), pancytopenia (a blood disorder that occurs when the bone marrow does not form all three types of blood cells - red, white, and platelets), history of falling, and aortic valve stenosis (narrowing of the valve in the large blood vessel branching off the heart). Resident CR82's	P 5280		

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P 5280	Continued from page 11 admission record indicated that Resident CR82 was discharged on 10/31/24, at 2:30 p.m. to home. Resident CR82's clinical record lacked documentation of the actual disposition of medications to include the name of the staff disposing of the medication, resident's name, medication name, strength of the medication, the prescription number (if applicable), the quantity of medication, method of disposition, and the date of disposition when Resident CR82 was discharged to home on 10/31/24. Resident CR83's clinical record revealed and admission date of 4/10/24, with diagnoses that included diabetic ulcers of both feet, end-stage renal disease and dependence on dialysis (procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly), Type 2 Diabetes (condition that happens because of a problem in the way the body regulates and uses sugar as a fuel), and peripheral vascular disease	P 5280		

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P 5280	Continued from page 12 (condition where the blood vessels outside the heart and brain become narrowed or blocked, reducing blood flow to the limbs). A departmental progress notes date 11/10/24, indicated that he/she had been transported to the acute hospital for evaluation and Resident CR83's census record revealed that he/she had not returned to the facility. Resident CR83's clinical record lacked documentation of the actual disposition of medications to include the name of the staff disposing of the medication, resident's name, medication name, strength of the medication, the prescription number (if applicable), the quantity of medication, method of disposition, and the date of disposition when he/she did not return from the hospital. During an interview on 1/31/25, at 12:53 p.m. the Regional Clinical Consultant that Resident CR81's clinical record lacked documentation of the actual disposition of medications when he/she ceased to breathe on 11/15/24, and also the clinical records	P 5280		

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P 5280	Continued from page 13 lacked documentation of the disposition of medications for Resident CR82 who was discharged to home on 10/31/24, and Resident CR83 when he/she did not return from the hospital.	P 5280		
P 5520		P 5520		

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P 5520	Continued from page 14 Nursing services. (3) Effective July 1, 2024, a minimum of 1 nurse aide per 10 residents during the day, 1 nurse aide per 11 residents during the evening, and 1 nurse aide per 15 residents overnight. This REGULATION is not met as evidenced by:	P 5520	The facility must maintain the minimum of one nursing assistant for every 10 residents during the day shift, a minimum of one nursing assistant for every 11 residents for the evening shift and a minimum of one nursing assistant for every 15 residents for the overnight shift. To ensure that this regulatory requirement is met the following action plan will be implemented: Education was provided to the scheduler February 4, 2025 and will be provided to the Director of Nursing by the Administrator to ensure that they understand the regulatory staffing requirements for nursing assistants as they are the 2 staff members who cover call off scheduling on the off shifts and weekends. The nursing assistant schedule will be reviewed by the scheduler and Director of Nursing to ensure that nursing assistant ratios are met prior to posting of the schedule. In the event of call-offs by staff, all other staff/agency will be contacted to cover any open shifts to ensure	Completion Date: **03/28/2025** Status: **APPROVED** Date: **03/03/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5520	Continued from page 15	P 5520	ratios are met. An audit will be developed and completed by the Director of Nursing or Designee daily for 4 weeks, then 3 times a week for 3 weeks, then 2 times a week for 2 weeks then weekly ongoing, to ensure that nursing assistant ratios are met for the all shifts. The audit will be monitored by the Administrator. Results of the audit will be presented at the Quality Assurance monthly meeting and recommendations will be implemented. All supporting documents will be kept in the Human Resource office so that they are available for review upon request.	

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P 5520	Continued from page 16 Based on review of facility nursing staffing documents and staff interview, it was determined that the facility failed to ensure a minimum of one Nurse Aide (NA) per 10 residents on the day shift for four of 21 days reviewed (7/28/24 through 7/31/24); failed to ensure one NA per 11 residents on the evening shift for six of 21 days (7/25/24,7/26/24, and 7/28/24 through 7/31/24); and failed to ensure a minimum of one NA per 15 residents on the overnight shift for five of 21 days reviewed for staffing (7/26/24, and 7/28/24, through 7/31/24). Findings include: Review of facility nursing staffing documents for the time periods of 7/25/24 through 7/31/24, 12/29/24 through 1/04/25, and 1/24/25 through 1/30/25, revealed following NA shortages for the day shift: 7/28/24 facility census of 77 residents 0.00 NAs worked and 7.70 were required. 7/29/24 facility census of 77 residents	P 5520		

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P 5520	Continued from page 17 0.00 NAs worked and 7.70 were required. 7/30/24 facility census of 78 residents 0.00 NAs worked and 7.80 were required. 7/31/24 facility census of 79 residents 0.00 NAs worked and 7.90 were required. Review of facility nursing staffing documents for the time periods of 7/25/24 through 7/31/24, 12/29/24 through 1/04/25, and 1/24/25 through 1/30/25, revealed following NA shortages for the evening shift: 7/25/24 facility census of 77 residents 5.33 NAs worked and 7.00 were required. 7/26/24 facility census of 76 residents 4.50 NAs worked and 6.91 were required. 7/28/24 facility census of 77 residents 0.00 NAs worked and 7.00 were required. 7/29/24 facility census of 77 residents 0.00 NAs worked and 7.00 were required. 7/30/24 facility census of 78 residents 0.00 NAs worked and 7.09 were required. 7/31/24 facility census of 79 residents	P 5520		

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P 5520	Continued from page 18 0.00 NAs worked and 7.18 were required. Review of facility nursing staffing documents for the time periods of 7/25/24 through 7/31/24, 12/29/24 through 1/04/25, and 1/24/25 through 1/30/25, revealed following NA shortages for the night shift: 7/26/24 facility census of 76 residents 3.52 NAs worked and 5.07 were required. 7/28/24 facility census of 77 residents 0.00 NAs worked and 5.13 were required. 7/29/24 facility census of 77 residents 0.00 NAs worked and 5.13 were required. 7/30/24 facility census of 78 residents 0.00 NAs worked and 5.20 were required. 7/31/24 facility census of 79 residents 0.00 NAs worked and 5.27 were required. During an interview on 1/31/25, at 3:30 p.m. the Nursing Home Administrator confirmed that the facility was unable to provide all required staffing information requested during the survey and failed to meet the minimum NA ratio requirements on the	P 5520		

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P 5520	Continued from page 19 above shifts and dates.	P 5520		
P 5530		P 5530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5530	Continued from page 20 Nursing services. (4) Effective July 1, 2023, a minimum of 1 LPN per 25 residents during the day, 1 LPN per 30 residents during the evening, and 1 LPN per 40 residents overnight. This REGULATION is not met as evidenced by:	P 5530	The facility must maintain the minimum of one LPN for every 25 residents during the day shift, a minimum of one LPN for every 30 residents for the evening shift and a minimum of one LPN for every 40 residents for the overnight shift. To ensure that this regulatory requirement is met the following action plan will be implemented: Education was provided to the scheduler February 4, 2025 and will be presented to the Director of Nursing by the Administrator to ensure that they understand the regulatory staffing requirements for Licensed Practical Nurses. The LPN schedule will be reviewed by the scheduler and Director of Nursing to ensure that LPN ratios are met prior to posting of the schedule. In the event of call-offs by staff, all other staff/agency will be contacted to cover any open shifts to ensure ratios are met. The Assistant Director of Nursing and or the Scheduler are responsible for handling call offs on the off shifts	Completion Date: **03/28/2025** Status: **APPROVED** Date: **03/03/2025**

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P 5530	Continued from page 21	P 5530	and weekends. An audit will be developed and completed by the Director of Nursing or Designee daily for 4 weeks, then 3 times a week for 3 weeks, then 2 times a week for 2 weeks then weekly ongoing, to ensure that LPN ratios are met for the day, evening and overnight shifts. The audit will be monitored by the Administrator or Designee. Results of the audit will be presented at the Quality Assurance monthly meeting and recommendations will be implemented. All supporting documents will be kept in the Human Resource office so that they are available for review upon request.	

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P 5530	Continued from page 22 Based on review of facility nursing staffing documents and staff interview, it was determined that the facility failed to ensure a minimum of one Licensed Practical Nurse (LPN) per 25 residents on the day shift for three of 21 days reviewed (7/29/24 through 7/31/24); failed to ensure one LPN per 30 residents on the evening shift for four of 21 days (7/28/24 through 7/31/24); and failed to ensure a minimum of one LPN per 40 residents on the overnight shift for six of 21 days reviewed for staffing (7/26/24 through 7/31/24). Findings include: Review of facility nursing staffing documents for the time periods of 7/25/24 through 7/31/24, 12/29/24 through 1/04/25, and 1/24/25 through 1/30/25, revealed following LPN shortages for the day shift: 7/29/24 facility census of 77 residents 0.00 LPNs worked and 3.08 were required. 7/30/24 facility census of 78 residents 0.00 LPNs worked and 3.12 were required.	P 5530		

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P 5530	Continued from page 23 7/31/24 facility census of 79 residents 0.00 LPNs worked and 3.16 were required. Review of facility nursing staffing documents for the time period of 7/25/24 through 7/31/24, 12/29/24 through 1/04/25, and 1/24/25 through 1/30/25, revealed following LPN shortages for the evening shift: 7/28/24 facility census of 77 residents 0.00 LPNs worked and 2.57 were required. 7/29/24 facility census of 77 residents 0.00 LPNs worked and 2.57 were required. 7/30/24 facility census of 78 residents 0.00 LPNs worked and 2.60 were required. 7/31/24 facility census of 79 residents 0.00 LPNs worked and 2.63 were required. Review of facility nursing staffing documents for the time period of 7/25/24 through 7/31/24, 12/29/24 through 1/04/25, and 1/24/25 through 1/30/25, revealed following LPN shortages for the night shift:	P 5530		

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	395262	A. BLDG: 00 B. WING:	02/04/2025

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GREENFIELD HEALTHCARE AND REHABILITATION CENTER STATE LICENSE NUMBER: **490802**	**1521 WEST 54TH STREET ERIE, PA 16509**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
P 5530	Continued from page 24 7/26/24 facility census of 76 residents 1.07 LPNs worked and 1.90 were required. 7/27/24 facility census of 76 residents 1.07 LPNs worked and 1.90 were required. 7/28/24 facility census of 77 residents 0.00 LPNs worked and 1.93 were required. 7/29/24 facility census of 77 residents 0.00 LPNs worked and 1.93 were required. 7/30/24 facility census of 78 residents 0.00 LPNs worked and 1.95 were required. 7/31/24 facility census of 79 residents 0.00 LPNs worked and 1.98 were required. During an interview on 1/31/25, at 3:30 p.m. the Nursing Home Administrator confirmed that the facility was unable to provide all required staffing information requested during the survey and failed to meet the minimum LPN ratio requirements on the above shifts and dates.	P 5530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395262	A. BLDG: __00_____ B. WING: _____	02/04/2025

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P 5640		P 5640		

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P 5640	Continued from page 26 Nursing services. (2) Effective July 1, 2024, the total number of hours of general nursing care provided in each 24-hour period shall, when totaled for the entire facility, be a minimum of 3.2 hours of direct resident care for each resident. This REGULATION is not met as evidenced by:	P 5640	The facility must maintain a minimum of 3.2 general nursing care hours for each 24-hour period. To ensure that this regulatory requirement is met, the following will be implemented: Education will be provided to the scheduler and Licensed Staff by the Director of Nursing/Designee on February 26, 2025 to ensure that they understand the regulatory requirement for general nursing care hours. Education was also provided to the Director of Nursing by the Administrator. The nursing schedule will be reviewed by the scheduler and Director of Nursing weekly to ensure that general nursing care hours are met prior to posting of the schedule. In the event of call-offs by staff, all other staff as well as those from our sister facilities will be contacted by the scheduler, Director of Nursing or Licensed staff to cover any open shifts to ensure that general nursing care hours are met. Shift bonuses	Completion Date: **03/28/2025** Status: **APPROVED** Date: **03/03/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5640	Continued from page 27	P 5640	will also be offered as an incentive for shift pickups. The facility also utilizes a recruitment company to acquire qualified staff. An audit of the daily nursing schedules will be developed and completed by the Director of Nursing or Designee daily for 4 weeks, then 3 times a week for 3 weeks, then 2 times a week for 2 weeks then weekly ongoing, to ensure that a minimum of 3.20 general nursing care hours for each 24-hour period are met. The audit will be monitored by the Administrator. Results of the audit will be presented at the Quality Assurance monthly meeting and recommendations will be implemented. All supporting documents will be kept in the Human Resource office so that they are available for review upon request.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5640	Continued from page 28 Based on review of facility nursing staffing documents and staff interview, it was determined that the facility failed to provide the minimum number of general nursing care hours of 3.2 hours of direct resident care hours per resident in a twenty-four-hour period for six of 21 days reviewed (7/25/24, 7/26/24, 7/28/24, 7/29/24, 7/30/24, and 7/31/24). Findings include: Review of facility nursing staffing documents for the time periods of (7/25/24 through 7/31/24), (12/29/24 through 1/04/25), and (1/24/25 through 1/30/25), revealed that the hours of direct resident care was below 3.2 minimum per patient per day (PPD) on the following dates: 7/25/24 3.10 PPD 7/26/24 2.99 PPD 7/28/24 0.64 PPD 7/29/24 0.31 PPD 7/30/24 0.32 PPD	P 5640		

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P 5640	Continued from page 29 7/31/24 0.30 PPD During an interview on 1/31/25, at 3:30 p.m. the Nursing Home Administrator confirmed that the facility unable to provide all required staffing information requested during the survey to calculate PPD accurately for all days and did not meet the 3.2 minimum hours of direct resident care on above dates.	P 5640		

Certified End Page

GREENFIELD HEALTHCARE AND REHABILITATION CENTER

STATE LICENSE NUMBER: 490802

SURVEY EXIT DATE: 02/04/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeanne Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen MD
Debra L. Bogen, MD, FAAP
Secretary of Health

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY